ARKANSAS INSURANCE DEPARTMENT
LICENSE DIVISION
1200 WEST 3RD STREET
LITTLE ROCK, AR 72201
PHONE: 501-371-2750
FAX: 501-683-2604

SELF-FUNDED SINGLE EMPLOYER PLANS, COLLECTIVELY BARGAINED WELFARE BENEFIT PLANS, MUTIPLE EMPLOYER TRUSTS AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (Ark. Code Ann. § 23-92-101)

1. Name of Plan:_____

2. Tax ID Number of Plan: _____

3. Address of Plan: _____

4. Contact Name and Title _____ Telephone No._____

5. Type of Plan, Arrangement, Association or Trust:

   ☐ Self Funded Single Employer Plan
   ☐ Collectively Bargained Welfare Benefit Plan (Taft-Hartley Trust)
   ☐ Multiple Employer Trust
   ☐ Fully Insured Multiple Employer Welfare Arrangement
   ☐ Not Fully Insured Multiple Employer Welfare Arrangement

6. List all States in which the Plan is registered or licensed (attach copies of license/registration to this form):

   _____

   _____

7. List all States in which the Plan is doing business or covers individuals:

   _____

   _____

8. Has the Plan had any complaints regarding claim payment in other states: ☐ Yes ☐ No
   (If yes, attach a copy of the documentation of the complaint and documentation of the resolution of the complaint)

9. Third Party Administrator: Name_____

   Federal Tax ID_____ Address _____

   Contact Name and Title _____ Tel. No. _____

10. Number of Individual Arkansas Residents Covered by the Plan or Arrangement_____

11. If a fully insured multiple employer welfare arrangement or trust, state name, address and telephone number and the NAIC number of the disability or health insurer underwriting the plan: *(A copy of the declaration page/ certificate and policy must be attached to this application.)*

    Name of Company _____ NAIC #_____

    Contact Name and Title _____ Tel. No. _____

12. If a multiple employer welfare arrangement or trust which is not fully insured, state name, address and telephone number of person(s) administering the plan, whether or not a third party administrator.

    Name of Administrator _____

    Address of Administrator _____

    Contact Name and Title _____ Tel. No. _____

AFFIDAVIT

I, the undersigned, do hereby swear or affirm under oath that the information submitted above is true and accurate to the best of my knowledge and belief.

Name and Title _____Date _____

State of _____
County of _____

Subscribed to and sworn or affirmed before me on this _____ Day of _____, 20____.

My Commission Expires: _____

Seal

_____
Notary Public